

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155238		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/22/2011	
NAME OF PROVIDER OR SUPPLIER WATERS OF YORKTOWN, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 2000 S ANDREWS RD YORKTOWN, IN 47396			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00086326, IN00086363, and IN00086414.</p> <p>Complaint IN00086326 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00086363 - Substantiated. No deficiencies related to the allegation are cited.</p> <p>Complaint IN00086414 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: February 20, 21, 22, 2011</p> <p>Facility number: 000143 Provider number: 155238 AIM number: 100283890</p> <p>Surveyor: Jeri Curtis, RN</p> <p>Census bed type: SNF/NF: 79 Total: 79</p> <p>Census payor type: Medicare: 10 Medicaid: 54 Other: 15 Total: 79</p> <p>Sample: 5</p> <p>The Waters of Yorktown was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaints IN00086326, IN00086363, and IN00086414.</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Quality review completed 2/25/11 by Jennie Bartelt, RN.			F 000			